Complete the enclosed application for BlueCHIP and/or the Caring Program for Children Today!

Insurance is provided by:
Highmark Blue Cross Blue Shield
Keystone Health Plan West
(Independent Licensees of the Blue Cross and Blue Shield Association)

Both programs are administered by:
Western Pennsylvania Caring Foundation For Children
P.O. Box CARING
Pittsburgh, PA 15230
Toll-Free: 1 (800) 543-7105
Fax: (412) 394-7395

Your child may qualify for free health insurance!

HIGHMARK.
Blue Cross Blue Shield
An Independent Licensee of the Blue Cross and Blue Shield Association

APPLICATION ENCLOSED

HOW CAN I FIND OUT IF MY CHILD QUALIFIES?

Complete the application and mail it back to the Western Pennsylvania Caring Foundation For Children in the postage paid envelope. We will review the information and send you a letter. The letter will let you know whether or not your child qualifies.

Children who qualify will be enrolled in the order we receive their application. Insurance will be provided by Highmark Blue Cross Blue Shield, and/or Keystone Health Plan West (a Blue Cross and Blue Shield HMO), depending on which county the child resides in.

To qualify, your child(ren) must:

1. Be a Pennsylvania resident
2. Be under age 19
3. NOT be enrolled in any other insurance program
4. NOT be eligible for public health insurance such as Medical Assistance (ACCESS), Medicaid, Healthy Beginnings, or Gateway
5. Meet the age, family size and income guidelines (SEE CHART ON PAGE 4)
6. Be enrolled in school (if school age - Caring Program only)

Questions?

Call the Western Pennsylvania Caring Foundation For Children:
1 (800) KIDS-105
(543-7105)

INSURANCE PROGRAMS AVAILABLE

Currently, there are five insurance programs available to uninsured children in Western Pennsylvania (SEE CHART ON PAGE 5 FOR PROGRAM COVERAGE). The following is a brief description of each program including pricing information, if it applies. Coverage Benefits appear on page 6.

- **FREE BlueCHIP (Ages 1 thru 16) and**
- **FREE Caring Program for Children (Ages 17 thru 18)**

Premiums are not required for these two programs. Please look at the income eligibility chart on page 4 to determine if your child(ren) is (are) eligible for Free coverage.

- **Low-Cost BlueCHIP (Ages Birth thru 5) and**
- **Low-Cost Caring Program for Children (Ages 6 thru 18)**

A premium is required for these two programs. Currently, the monthly premium is $20 for each child per month, $40 for two children per month, and a maximum of $50 per month for three or more children. Review the income eligibility chart on page 4 to determine if your child(ren) is (are) eligible for Low-Cost coverage.

- **Medical Assistance (All Ages)**

A federal and state supported program that is administered by a network of County Assistance Offices.

Contact the County Assistance Office in your county for eligibility information. If your child is denied coverage under Medical Assistance, he/she may be eligible for one of our programs.

WAITING LISTS

If your child is eligible for Free or Low-Cost BlueCHIP and no openings are available on the program, you will have the option to buy coverage for your child(ren) while they are on the waiting list. This option is NOT available for the Caring Program for Children. Electing to buy coverage while your child is waiting for BlueCHIP WILL NOT affect your child's position on the waiting list. Premiums for this "At Cost" coverage are approximately $50 to $70 per month per child. You will be required to pay the first two months of coverage up front and will be billed monthly thereafter until a slot on BlueCHIP becomes available.

PROGRAM FUNDING

The entire amount for the Free programs and the remaining amount due for the Low-Cost programs is paid by either the Commonwealth of Pennsylvania (for the BlueCHIP program) or by Highmark Blue Cross Blue Shield matching of private donations from churches, schools, businesses, civic groups, etc. (for the Caring Program for Children). Highmark Blue Cross Blue Shield currently donates all administrative costs for the Caring Program for Children and a portion of the administrative costs for BlueCHIP. The Western Pennsylvania Caring Foundation For Children provides administration and service for the programs.

BlueCHIP and Caring Program Eligibility Chart

DETERMINING ELIGIBILITY

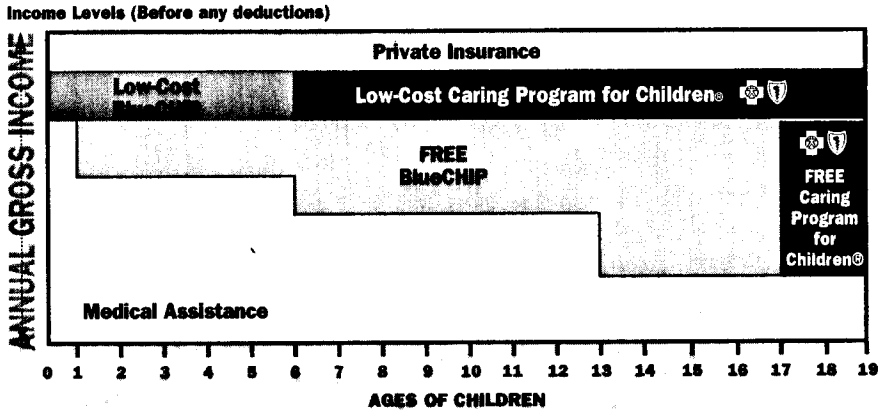
To use this chart follow these steps:

1. Locate your family size on the left hand side (this includes all family members under age 19, you and your spouse).
2. For each child, locate their age range in the second row.
3. Note the applicable income range for each child in the appropriate row for your family size.
4. If your CURRENT GROSS ANNUAL income falls within the range for your child(ren)'s age, your child may be eligible. (To determine your current gross annual family income, turn to pages 7 and 8).
5. Finally, you can locate each child's program on the Health Insurance Programs chart on the next page.

Family Size	FREE COVERAGE*			LOW-COST COVERAGE
	BlueCHIP: Ages: 1 thru 5	BlueCHIP: Ages: 6 thru 12	BlueCHIP: Ages: 13 thru 16 Caring Program: Ages: 17 thru 18	BlueCHIP: Ages: Birth thru 5 Caring Program: Ages: 6 thru 18
2	$14,111-19,629	$10,610-19,629	$5,300-19,629	$19,630-24,934
3	$17,729-24,661	$13,330-24,661	$5,600-24,661	$24,662-31,326
4	$21,347-29,693	$16,050-29,693	$6,800-29,693	$29,694-37,718
5	$24,964-34,725	$18,770-34,725	$8,100-34,725	$34,726-44,110
6	$28,582-39,757	$21,490-39,757	$9,100-39,757	$39,758-50,502
7	$32,199-44,789	$24,210-44,789	$10,200-44,789	$44,790-56,894
8	$35,817-49,821	$26,930-49,821	$11,300-49,821	$49,822-63,286

* For Free Coverage, if your family income is less than the range shown under your child's age, that child may be eligible for Medical Assistance.

HEALTH INSURANCE PROGRAMS



USING THE ELIGIBILITY CHART (on page 4):

AN EXAMPLE:

Family Size = 4

There are 2 children:

Jane = 3 years old

Bob = 10 years old

Annual Current Gross Income = $17,600.00

Since the family income is less than the range shown for a family of four with a three year old, Jane may be eligible for Medical Assistance and the Caring Foundation would send a letter with an application for Medical Assistance. Bob would be eligible for Free BlueCHIP (ages 6 thru 12).

WHAT BENEFITS ARE AVAILABLE?

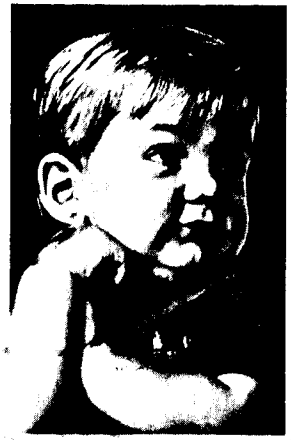
Benefits include:

- Check-ups, Immunizations, & Doctor Visits
- Diagnostic Tests
- Emergency Care
- Outpatient Surgery
- Dental, Vision & Hearing Care
- Prescription Drugs (with a $5 co-pay)
- Mental Health Care
- Inpatient Hospital Care*

* **Medical Assistance Spend Down** is a federal and state supported program that may pay for some or all of your child's hospital charges. The use of this money will enable us to serve more children. Therefore, you must apply for Spend Down anytime your child is admitted to a hospital or mental health facility. Failure to apply will result in cancellation of your child's coverage from these programs.

Inpatient hospital benefits are available under these programs ONLY after application has been made for Medical Assistance Spend Down and the inpatient charges (in part or in total) are determined not eligible for payment under Medical Assistance Spend Down. An application can be obtained at the hospital or your County Assistance Office. BlueCHIP and the Caring Program will pay any eligible expenses that are not covered by Medical Assistance including your patient pay liability.

HOUSEHOLD INCOME INFORMATION



On the application form, please check **each** income source for which **your household** received money over the past 12 months. **Attach copies of each source of current income** as noted in the Income Sources directions on page 8. Read the income directions carefully.

Calculate your household's TOTAL ANNUAL INCOME based on your CURRENT GROSS income. (Do not use last year's tax return amount unless you are self-employed and the tax return is your income documentation.)

To calculate ANNUAL INCOME, multiply each of your **current gross income** sources (before any deductions) by the number of times you will receive the income amount this year. Weekly income should be multiplied by 52, bi-weekly by 26, semi-monthly by 24 and monthly by 12. For unemployment payments, multiply weekly amount by the number of payments remaining (of the total benefit weeks).

Proof of Residency:
Attach a copy of either;

- Your current PA Driver's License, or
- A current gas or electric bill

Income Changes:
Always contact us if your income changes.

INCOME SOURCES

Attach copies of the following income sources for all income used to support your household:

- Alimony Award Letter from Court
- Child Support Award Letter
- Disability Checks (Award Letter or most recent Check Stub)
- Income Tax Return (for Self-Employed individuals ONLY. Most current return.)
- Pay Check Stubs (for past 2 pay periods if you are paid bi-weekly, 4 if you are paid weekly)
- Pension Check (for most recent payment)
- Social Security or Survivors Benefits Check Stub (for most recent payment)
- Stipend Award Letter
- Unemployment Compensation Check Stubs or Determination Letter (2 most recent stubs)
- Veterans Benefit Check (2 most recent stubs)
- Workers' Compensation Check Stubs or notice of Compensation Payable (2 most recent stubs)

For direct deposit amounts where copies of income documentation are not available, attach a copy of your most recent bank statement. For alimony and child support, note whether you have received these payments during each of the past three months. If none of the above income documents are available, call the Western Pennsylvania Caring Foundation For Children.

ORIGINALS WILL NOT BE RETURNED!

BEFORE YOU MAIL OR FAX YOUR CHILD'S APPLICATION

Make sure you have completed each of the following steps:

- ❑ Check your child(ren)'s social security numbers
- ❑ Make sure you marked an answer for each question
- ❑ Re-calculate your annual household income and make sure you wrote an amount in the Income Information Section on the application
- ❑ Make sure you attach copies of **each** source of income for your household
- ❑ Make sure you attach a copy of your current PA Driver's License, or a current gas or electric bill
- ❑ Make sure you sign the application

Write, call, or fax the Caring Foundation if you have questions!

Western Pennsylvania
Caring Foundation
For Children
P.O. Box CARING
Pittsburgh, PA 15230

PHONE:
1 (800) KIDS-105
(543-7105)

FAX:
(412) 544-1657

APPLICATION FOR ENROLLMENT

PLEASE COMPLETE BOTH SIDES OF FORM

WESTERN PENNSYLVANIA CARING FOUNDATION FOR CHILDREN

00756025

PARENT INFORMATION PLEASE PRINT ALL INFORMATION CLEARLY

If you have more than four children under 19, or need additional applications, please call 1-800-543-7105. Si necesita esta informacion en Español, llame al telefono 1-800-543-7105.

PARENT (OR GUARDIAN) LAST NAME | FIRST NAME | MIDDLE INITIAL

STREET ADDRESS

CITY | STATE | ZIP CODE | COUNTY

SOCIAL SECURITY NO. | HOME PHONE (include area code) ( ) | WORK PHONE (include area code) ( )

MARITAL STATUS: ❑ DIVORCED/SEPARATED (01) ❑ MARRIED (02) ❑ SINGLE (03) ❑ WIDOWED (04)

CHILD(REN)'S INFORMATION YOU MUST COMPLETE BELOW FOR EACH CHILD IN IMMEDIATE FAMILY UNDER 19.

1 CHILD'S LAST NAME | FIRST NAME | MIDDLE INITIAL | ❑ MALE ❑ FEMALE

BIRTHDATE | SOCIAL SECURITY NO.

NAME OF SCHOOL

HAS THIS CHILD BEEN A PENNSYLVANIA RESIDENT FOR 30 DAYS OR MORE? ❑ YES ❑ NO

YOUR RELATIONSHIP TO CHILD: ❑ PARENT ❑ GUARDIAN

IS THIS CHILD ENROLLED IN MEDICAL ASSISTANCE (INCLUDING MEDICAID, ACCESS, GATEWAY, OR HEALTHY BEGINNINGS)? ❑ YES ❑ NO

IS THIS CHILD ENROLLED IN ANY OTHER HEALTH INSURANCE COVERAGE? ❑ YES ❑ NO NAME OF PLAN: _____ END DATE FOR OTHER INSURANCE: _____

NAME OF CHILD'S CURRENT DOCTOR:

DOCTOR'S OFFICE ADDRESS:

2 CHILD'S LAST NAME | FIRST NAME | MIDDLE INITIAL | ❑ MALE ❑ FEMALE

BIRTHDATE | SOCIAL SECURITY NO.

NAME OF SCHOOL

HAS THIS CHILD BEEN A PENNSYLVANIA RESIDENT FOR 30 DAYS OR MORE? ❑ YES ❑ NO

YOUR RELATIONSHIP TO CHILD: ❑ PARENT ❑ GUARDIAN

IS THIS CHILD ENROLLED IN MEDICAL ASSISTANCE (INCLUDING MEDICAID, ACCESS, GATEWAY, OR HEALTHY BEGINNINGS)? ❑ YES ❑ NO

IS THIS CHILD ENROLLED IN ANY OTHER HEALTH INSURANCE COVERAGE? ❑ YES ❑ NO NAME OF PLAN: _____ END DATE FOR OTHER INSURANCE: _____

NAME OF CHILD'S CURRENT DOCTOR:

DOCTOR'S OFFICE ADDRESS:

3 CHILD'S LAST NAME | FIRST NAME | MIDDLE INITIAL | ❑ MALE ❑ FEMALE

BIRTHDATE | SOCIAL SECURITY NO.

NAME OF SCHOOL

HAS THIS CHILD BEEN A PENNSYLVANIA RESIDENT FOR 30 DAYS OR MORE? ❑ YES ❑ NO

YOUR RELATIONSHIP TO CHILD: ❑ PARENT ❑ GUARDIAN

IS THIS CHILD ENROLLED IN MEDICAL ASSISTANCE (INCLUDING MEDICAID, ACCESS, GATEWAY, OR HEALTHY BEGINNINGS)? ❑ YES ❑ NO

IS THIS CHILD ENROLLED IN ANY OTHER HEALTH INSURANCE COVERAGE? ❑ YES ❑ NO NAME OF PLAN: _____ END DATE FOR OTHER INSURANCE: _____

NAME OF CHILD'S CURRENT DOCTOR:

DOCTOR'S OFFICE ADDRESS:

4 CHILD'S LAST NAME | FIRST NAME | MIDDLE INITIAL | ❑ MALE ❑ FEMALE

BIRTHDATE | SOCIAL SECURITY NO.

NAME OF SCHOOL

HAS THIS CHILD BEEN A PENNSYLVANIA RESIDENT FOR 30 DAYS OR MORE? ❑ YES ❑ NO

YOUR RELATIONSHIP TO CHILD: ❑ PARENT ❑ GUARDIAN

IS THIS CHILD ENROLLED IN MEDICAL ASSISTANCE (INCLUDING MEDICAID, ACCESS, GATEWAY, OR HEALTHY BEGINNINGS)? ❑ YES ❑ NO

IS THIS CHILD ENROLLED IN ANY OTHER HEALTH INSURANCE COVERAGE? ❑ YES ❑ NO NAME OF PLAN: _____ END DATE FOR OTHER INSURANCE: _____

NAME OF CHILD'S CURRENT DOCTOR:

DOCTOR'S OFFICE ADDRESS:

HOUSEHOLD INFORMATION

Total number in immediate family
(include yourself, your spouse and your children under 19 years of age) _____

How many children under 19? . . . . . _____

(Completion of the following two questions is voluntary.
This information will not be used to determine eligibility.)

Is your family of Hispanic origin? ❑ Yes ❑ No

Which of the following best describes your family's race?
❑ American Indian or Alaskan Native (01) ❑ Asian/Pacific Islander (02)
❑ Black (03) ❑ White (04) ❑ Other (05) _____ *(Specify)*

INCOME INFORMATION/VERIFICATION

Please read Income Information on pages 7 and 8 before filling in this section.

Please check each income that applies and write an amount on the line next to it:
❑ Alimony_____
❑ Child Support _____
❑ Disability _____
❑ Self-Employed Earnings _____
❑ Wages _____
❑ Pension _____
❑ Social Security _____
❑ Survivor Benefits _____
❑ Stipends _____
❑ Unemployment _____
❑ Veteran Benefits _____
❑ Worker's Comp _____
❑ Other (please describe) _____

You must attach COPIES of EACH source of income as noted in the Income Sources Section on page 8.

ADD ALL OF THE AMOUNTS TOGETHER AND WRITE YOUR TOTAL GROSS CURRENT ANNUAL HOUSEHOLD INCOME AMOUNT HERE:

$ _____

Gross per YEAR
(based on your
current income)

NOTIFICATION, AUTHORIZATION AND SIGNATURE

As part of the Western Pennsylvania Caring Foundation For Children's procedure for processing this application, an investigation may be made to verify the information provided on this application. This information may be obtained from employers, financial sources, or other third parties.

I understand that: enrollment and the availability of benefits through BlueCHIP of Pennsylvania is subject to continued adequate funding from the Commonwealth of Pennsylvania; enrollment and the availability of benefits through the Caring Program for Children is subject to continued adequate funding from private sector donations.

I hereby certify that I have read and fully understand this application, and have responded to the preceding questions truthfully. Any person or organization having provided or who may provide health care services to me or any person named on this application either prior to or during the period of this contract is authorized to furnish any information or records relating to these services.

By placing my signature below, I indicate that if my children are enrolled in the BlueCHIP of Pennsylvania program or the Caring Program for Children, I agree to make application for Medical Assistance Spend-Down should any of my children require admission to a hospital or mental health facility.

In the event that some or all of my children do not qualify for BlueCHIP of Pennsylvania or the Caring Program for Children, but may qualify for Medical Assistance, I authorize the Western Pennsylvania Caring Foundation For Children to release my name and the information contained on this application to the Department of Public Welfare, or other appropriate entity.

I further certify that application is being made for all my children, and understand that for those who are accepted into the program, I am to notify the Western Pennsylvania Caring Foundation For Children if and when they no longer meet the program's eligibility requirements.

I understand that false statements made herein or fraudulent claims made hereunder are subject to the penalties of 18 PA CPSS 4117 relating to insurance fraud.

SIGNATURE **DATE**

MY CHILD(REN)'S SPECIAL HEALTH CARE NEEDS

IF your child has a special health care need (due to a chronic illness or disability), we may be able to direct you to sources of additional care. If any of your children have a chronic or disabling condition, please complete this section.

This information will NOT affect your child's eligibility. This information is confidential.

Do any of your children have a chronic illness or disability? ❑ YES ❑ NO

Child's Social Security Number(s) **Diagnosis** (List all for each child)

_____ _____
_____ _____
_____ _____
_____ _____

MEDICAL ASSISTANCE INFORMATION

If you have applied for ACCESS, Medicaid, Gateway, or Healthy Beginnings and have been DENIED coverage for your child, please attach a copy of a recent (within the past 60 days) MA 162 Denial form.

If your child is currently on MA, he or she will NOT be eligible for either BlueCHIP or the Caring Program. However, if you know when their MA coverage will be discontinued, you may apply for BlueCHIP or the Caring Program no more than 60 days before that coverage will end. In no event will a child be enrolled in either BlueCHIP or the Caring Program while they are enrolled in another plan.

MA Coverage Information: *Please list date(s) and attach a copy of the MA discontinuance notice for each child below:*

Child Name **MA Discontinuance Date**

_____ _____
_____ _____
_____ _____
_____ _____

REMEMBER TO ATTACH: INCOME DOCUMENTATION AND A COPY OF EITHER YOUR PA DRIVER'S LICENSE OR A GAS OR ELECTRIC BILL.